Runnemede Public Schools

Aline Bingham School 856-939-3192
Grace Downing School 856-939-4036
Mary E. Volz School 856-931-5353

SELF-MEDICATION DISPENSING FORM

FOR STUDENTS WITH ASTHMA OR OTHER POTENTIALLY LIFE-THREATENING ILLNESSES

Medication brought to school must be in a labeled prescription bottle.

Student's Name: _____ **Age:** _____ **Grade:** _____ **School:** _____

Medication Name: _____ **Prescription:**_____ **Non-Prescription:**____

Dosage & Schedule (During School):_____

_____

Route of Administration:_____ **Side Effects:** _____

Reason for Medication:_____

It is my understanding that the School Nurses of the Runnemede School District charged with the administration of medication may rely upon my directions as contained in this document. Students with Asthma or other potentially life-threatening illnesses deemed sufficiently responsible by their physician and parent shall be permitted to have in their possession prescribed medication for the treatment and prevention of life-threatening illnesses or conditions during school hours, athletic events & practices and field trips. **I hereby deem the above named student to be sufficiently capable, having been instructed in the proper method of self-administration of medication pursuant to Chapter 308 of the laws of 1993, to carry his or her prescribed medication on his or her person and give authorization for self-medication of the medication listed above.** I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

Physician's Signature:_____**Date**:_____

Address:_____**Telephone:**_____

As parent(s)/guardian(s) of the above named child, I/we hereby request permission for my/our child to self-administer and have possession of hi/her medication as described above and release the Runnemede School District and its employees from liability for damages my/our child may suffer as a result of this request. I realize self-management privileges are lost if he/she does not use medication properly. Students deemed responsible may carry their prescribed medication on their person, but must report to the School Nurse with the above prescribed medication before this policy can be instituted. **I also realize permission is effective for only the school year for which it is granted and must be renewed for each subsequent school year.**

Parent/Guardian Signature(s):_____**Date:**_____

_____**Date**:_____

Home telephone:_____**Work telephone:**_____

Note: All parents and/or Guardians must sign this form.